

of the ribs to the inguinal fold, and from the linea alba to the anterior axillary line, was occupied. The skin over it was of a bluish color, while the whole abscess was opened and scraped, the bottom being apparently formed by the transversalis fascia. A large quantity of pus was evacuated, containing numerous yellowish points, of the color of sulphur and of the size of a pin-head. The cavity was packed with iodoform gauze and dressed. On changing the dressing the cavity was granulating, and with but little secretion. He complained but little of his disease, and was only bothered by a hacking cough. The rhonchous and sibilant râles increased in number, his general condition became worse, œdema of the malleoli and lumbar region set in, actinomycotic rosettes were discovered, two abscesses developed in the right groin, which were opened, the dyspnoic attacks increased in severity, his strength became very reduced, the cough grew obstinate, though the expectoration was not profuse, and, finally, on February 23, 1889, he died. The necropsy revealed an actinomycotic perityphlitis, with infiltration of the iliac fossæ on both sides and the pubis, associated with chronic peritonitis, a hepatic and perihepatic abscess, with perforation into the pleural cavity and consequent double pleuritis and slight pericarditis. The duration of the disease was, in all, five months. The diagnosis made from the peculiarity of the tumor in having a fluctuating point in its centre and in its stalactite-like running to a point. The vermiform appendix was assumed to be the point of departure for the disease. Actinomycotic perityphlitis has recently been described by Dr. Otto Lanz (Corresp. *Bl. f. Schweizer Aerzte*, 10-11, 1892). The disease is rare in Norway.—*Norsk Magazin for Lægevidenskaben*, No. 12, 1892.

III. Strangulated Femoral Hernia Involving only Part of Circumference of Bowel; Enterectomy; Enterorrhaphy; Recovery. By R. BORELLA (Novaro, Italy). A peasant woman, fifty-four years of age, who had always been well and borne four children with normal labors, noticed a node of the size of a nut in the right groin when twenty-eight years of age. It had remained

indolent, appearing in the erect position and disappearing in the recumbent. She never wore a truss, as the tumor would not be visible for months at a time, and did not disturb her in her laborious daily work. October 13, while bending over the washtub, she was seized with a sharp pain in the right groin, which soon extended over the entire abdomen. She took to her bed, and an unsuccessful attempt at taxis was made. The next day vomiting set in, at first of a bilious and then of a fecal character. October 15, when transported to the hospital, she was weak, reduced in strength, her pulse small, frequent, the extremities cold, and the fecal vomiting still continuing. Her abdomen was slightly distended and painful to pressure. The two labia majora were eczematous. In the right groin were two tumors, one a small hydrocele of the round ligament, the second situated below Poupart's ligament, and internal to the femoral vessel. It was round, of the size of a chestnut, covered with normal integument, which could be lifted up in folds, dull on percussion, painful on pressure, the pains radiating into the abdominal cavity, non-fluctuating and irreducible. No increase in size on violent coughing. On account of the presence of the eczema it was thought to be a lympho-adenitis following the vulvar eruption, but the existence of the tumor before the eczema, its appearance when in the erect position and its disappearance in the horizontal position, together with the local pain radiating into the abdominal cavity, absence of the passage of feces and flatus, the fecal vomit and the state of collapse, led rather to the belief that the intestinal canal was obstructed. An operation was done the same afternoon. The hernial sac was found to consist of very thick peritonæum, the strangulated gut was discovered to be the small intestine, which was of a greyish red color, softened, inelastic and devoid of its epithelial sac. No adhesions between the walls of the sac or the crural ring could be made out. The gut was washed with an antiseptic solution, the hernial canal enlarged and about twelve centimetres of intestine and the appertaining mesentery drawn out, when it was observed that the strangulated portion involved but two-thirds of the circumference of the intestine and at the part opposite

to the mesenteric insertion, where the gut was of the normal rosy color, and in marked contrast with the brownish tint of the remainder of the viscus. Billroth's method of clamping was employed, the intervening portion, about six centimetres in length, resected with the straight scissors. After antiseptic washing of the intestine, the mucous layer was united by means of an overcast suture, after fastening the mesenteric border in the same manner, by which means complete hemostasis was obtained. The material used was Lister's catgut (No. 1). The serous and muscular coats were united by Lembert's suture, leaving five millimetres of the sero-muscular coat between the entrance and exit of the needle. The intestine was replaced in the abdomen, the walls of the hernial sac drawn together with a catgut suture and the sac resected at the distance of a centimetre from the suture, together with a second continuous buried suture. The post-operative course of the case was favorable, and, beyond slight vomiting from the chloroform there was nothing of importance observed. On the sixth day a hard and painful stool was passed, and, on the eighth day of continuous apyrexia the sutures were removed, and on the fourteenth day after the operation the patient left the hospital without a truss. She was seen again a month after and a solid cicatrix and good health reported.—*Gazzetta Medica Lombarda*, 1891.

FRANK H. PRITCHARD (Norwalk, O.).

IV. Report of Eight Cases of Cholecystotomy, with Remarks upon Technique. By Dr. ARTHUR T. CABOT (Boston). The author first mentions the difficulty of dislodging stones from narrow ducts. To overcome this he suggests the use of a narrow loop of wire, small enough to slip along a narrow duct, having its outer surface rounded and smooth, while the inner edge is somewhat sharp, so that it may hold on to the calculus, when it has once been passed beyond it. He next mentions the embarrassments that attend attempts to incise the walls of a deep-lying duct for the evacuation of a calculus more or less movable, while important organs and vessels are lying close about the duct to be incised. He suggests the use of